PRINTED: 02/20/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025	
	PROVIDER OR SUPPLIE Y CREEK AT FRAI		580 L	T ADDRESS, CITY, STATE, ZIP COD EMLEY STREET NKLIN, IN 46131		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/28/25 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Emergency Preparedness survey, Hickory Creek at Franklin was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 36 certified beds. At the time of the survey, the census was 27.		E 0000	This plan of correction constitution facility's written allegation compliance for the deficiencic cited. The submission of this of correction is not an admission or agreement with the deficience conclusions contained in the Indiana Department of Health's insperse Report. Hickory Creek at France respectfully requests consideration for desk review this plan of correction in lieur post survey revisit.	n of es plan n of ies or ection nklin		
E 0004 SS=C Bldg	403.748(a), 416.5 Develop EP Plan Annually Based on record re failed to review an Operations Plan (E	onducted on 01/30/25 54(a), 418.113(a), 441.1 , Review and Update view and interview, the facility d update the Emergency OP) at least annually in 2 CFR 483.73(a). This deficient et all occupants.	E 0004	Deficiency ID: E004 Completion Date: 2/23/25 Plan of Correction Text: Th facility requests Paper Compliance for this citation		02/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on records review and interview with the Maintenance Supervisor (MS) on 01/28/25

between 10:20 a.m. and 12:35 p.m., and no

documentation could be found to show the

TITLE

What corrective actions will be

residents found to have been

accomplished for those

(X6) DATE 02/18/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

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Oldham

continued program participation.

Tracie

Findings include:

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	PROVIDER OR SUPPLIEI		580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	and updated within interview during re an EOP from (1) hi	tons Plan (EOP) was reviewed the last year. Based on an cords review, the MS provided s office and (2) the nurse's		affected by the deficient practice?	
	station. The MS sea (ED) office and ma no additional EOP provided for review 01/03/24, over a ye This finding was ac Maintenance Super	arched the Executive Directors de a phone call to the ED but was located. The two EOP's v each reflected a review date of		- The alleged deficient practic has the potential to affect all facility occupants. No resider were identified. How other residents have the potential to be affected by the same deficient practice will identified and what correcting actions will be taken? - The alleged deficient practic has the potential to affect all facility occupants. No resider were identified. - The administrator reviewed updated the emergency oper plan including policies and procedures based on the fact and community-based risk assessment. The administrative refied all disaster prepared manuals are current, updated accessible. Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office The nurse's station. Current will be in-serviced regarding revisions to the emergency play Feb. 23, 2025. The Administrator or their designer review the plan at least annual.	he he be ve dice ints and rations dility dor ness d and rated ce 3. staff the blan be will
				The Administrator assumes responsibility for and ensures	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETED B. WING 01/28/2025		
	PROVIDER OR SUPPLIER Y CREEK AT FRANKLIN	580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	
			Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2025. The Administrator or their designee will review the plan at least annually. The Administrator assumes responsibility for and ensures compliance. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	
			-The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 months and then annually. The audit tool will be reviewed during the bi-monthly QAPI meeting. Action plans will be completed as needed.	
E 0013 SS=C Bldg	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures			
	Based on record review and interview, the facility failed to review and update the Emergency	E 0013	Deficiency ID: E013 Completion Date: 2/23/25	02/23/2025

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. BUILDING B. WING		COMP	E SURVEY PLETED 3/2025	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LE	ADDRESS, CITY, STATE, ZIF MLEY STREET KLIN, IN 46131	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	least annually in acc	OP) Policies and Procedures at cordance with 42 CFR cient practice could affect all		Plan of Correction To facility requests Pape Compliance for this of	er	
	Based on records re Maintenance Superbetween 10:20 a.m. documentation coul Policies and Proced updated within the linterview during rean EOP from (1) his station. The MS sea (ED) office and man additional EOP provided for review 01/03/24, over a year This finding was ac Maintenance Super			What corrective action accomplished for the found to have been a deficient practice? - The alleged deficient has the potential to a facility occupants. Nowere identified. How other residents potential to be affect same deficient practicity identified and what contact actions will be taken. - The alleged deficient has the potential to a facility occupants. Note that the potential to a facility occupants.	ose residents affected by the affected by the affected by the affect all be residents have the ed by the ice will be corrective ? affect all	
				-The administrator re- updated the emerger plan including policie procedures and the communication plan facility and communi assessment. The adverified all disaster p manuals are current, accessible. Manuals at the following locat	eviewed and ncy operations es and based on the ty-based risk ministrator reparedness updated and s are located	

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			X3) DATE SURVEY COMPLETED 01/28/2025		
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKL	HICKORY CREEK AT FRANKLIN		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131		
PREFIX (EACH DEFICIENCY N	ATEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) Administrators Office's 2. Environmental Service's Office The nurse's station. Current state will be in-serviced regarding the revisions to the emergency plate by Feb. 23, 2025. The Administrator or their designed review the plan at least annual The Administrator assumes responsibility for and ensures compliance. What measures will be put into place or what systemic change.	DATE e 3. taff ne an e will lly.	
			will be made to ensure that the deficient practice does not reconstructed. - Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 2. The Administrator or their designee will review the plan at least annually. The Administration assumes responsibility for and ensures compliance. How the corrective actions will monitored to ensure the deficity practice will not recur, i.e., who quality assurance program will put into place? -The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 month.	ed 025. at stor d l be ent at l be	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025		
	PROVIDER OR SUPPLIER		1	580 LEI	ADDRESS, CITY, STATE, ZIP COD MLEY STREET LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0029	403.748(c), 416.5	4(c), 418.113(c), 441.1		Me	bi-monthly QAPI meeting. Acti plans will be completed as needed.	on	DATE
SS=C Bldg	Based on record rev failed to review and Operations Plan (EC least annually in acc 483.73(a). This defi occupants.	ommunication Plan riew and interview, the facility update the Emergency DP) Communication Plan at cordance with 42 CFR cient practice could affect all	E 00	029	Deficiency ID: E029 Completion Date: 2/23/25 Plan of Correction Text: The facility requests Paper Compliance for this citation.		02/23/2025
	Maintenance Superbetween 10:20 a.m. documentation coul Communication Pla within the last year. records review, the his office and (2) th searched the Execut made a phone call twas located. The tw	view and interview with the visor (MS) on 01/28/25 and 12:35 p.m., and no d be found to show the n was reviewed and updated Based on an interview during MS provided an EOP from (1) to enurse's station. The MS tive Directors (ED) office and to the ED but no additional EOP to EOP's provided for review tiew date of 01/03/24, over a			What corrective actions will accomplished for those residents found to have been affected by the deficient practice? -The alleged deficient practice has the potential to affect all facility occupants. No resident were identified.	1	
	_	knowledged by the visor at the time of records the exit conference with the			How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The alleged deficient practice has the potential to affect alleged facility occupants. No residents were identified.	e e e e	

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	OF HEALTH AND HUR R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 01/28/2025				SURVEY .ETED
	PROVIDER OR SUPPLIER			580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET KLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					-The administrator reviewed an updated the emergency operar plan including policies and procedures based on the facility and community-based risk assessment. The administratory verified all disaster prepared to manuals are current, updated accessible. Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office The nurse's station. Current st will be in-serviced regarding the revisions to the emergency plate by Feb. 23, 2025. The Administrator or their designed review the plan at least annual The Administrator assumes responsibility for and ensures compliance. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? - Current staff will be in-serviced regarding the revisions to the emergency plan by Feb. 23, 20 The Administrator or their designee will review the plan at least annually. The Administrator and the process and the process and the plan at least annually. The Administrator and the process a	tions ty ress and ed a.aff ne an e will lly.	

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assumes responsibility for and

How the corrective actions will be monitored to ensure the deficient practice will not

ensures compliance.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/28/2025
	PROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
E 0030 SS=C Bldg	Based on record reversal failed to ensure the (EOP) includes nany the current staff. The affect all occupants Findings include: Based on records reversal failed to ensure the first three names represented on the learner to the first three three to the first three to the first three three to the first three thr	view and interview, the facility Emergency Operations Plan ness and contact information for is deficient practice could view and interview with the visor (MS) on 01/28/25 and 12:35 p.m., the facility's ation was not current. In each P's the communication plan did ted list of names and contact tent staff. The MS stated that is and contact information ist, which included the Director of Nursing and of Nursing, were all incorrect.	E 0030	recur, i.e., what quality assurance program will be into place? The Disaster and emergen preparedness QAPI tool will completed monthly for 6 morand then annually. The audit will be reviewed during the bi-monthly QAPI meeting. Ac plans will be completed as needed. Deficiency ID: E030 Completion Date: 2/23/25 Plan of Correction Text: The facility requests Paper Compliance for this citation. What corrective actions will accomplished for those residents found to have been affected by the deficient practice? -The alleged deficient practic has the potential to affect all facility occupants. No resider were identified.	cy be aths tool dition 02/23/2025 le

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	OF CORRECTION	IDENTIFICATION NUMBER 155442	A. BUILDING B. WING		COMPLETED 01/28/2025
	ROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET (LIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	review and again at MS present.	the exit conference with the		How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? - The alleged deficient practice has the potential to affect allefacility occupants. No resident were identified. -The administrator reviewed a updated the emergency operaplan including the names and contact information for staff, entities providing services, paphysicians, other facilities, and volunteers. The administrator verified all disaster prepared manuals are current, updated accessible. Manuals are local at the following locations: 1. Administrators Office's 2. Environmental Service's Office The nurse's station. Current swill be in-serviced regarding the revisions to the emergency plaby Feb. 23, 2025. The Administrator or their designer review the plan at least annual The Administrator assumes responsibility for and ensures compliance. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?	ne pe

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155442		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 01/28/2025					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				- Current staff will be in-service regarding the revisions to the emergency plan by Feb. 23, 20. The Administrator or their designee will review the plan a least annually. The Administration assumes responsibility for and ensures compliance. How the corrective actions with the beautiful place will not recur, i.e., what quality assurance program will be presented in the presented monthly for 6 months and then annually. The audit to will be reviewed during the bi-monthly QAPI meeting. Actiplans will be completed as needed.	o25. at tor iill ut y e ns pool		
E 0036 SS=C Bldg	403.748(d), 416.5 EP Training and T	4(d), 418.113(d), 441.1 esting					
Š	failed to review and Operations Plan (EC at least annually in	riew and interview, the facility update the Emergency DP) Training and Testing Plan accordance with 42 CFR cient practice could affect all	E 0036	Deficiency ID: E036 Completion Date: 2/23/25 Plan of Correction Text: The facility requests Paper Compliance for this citation.	02/23/2025		
	Findings include:						
	Based on records re	view and interview with the		What corrective actions will	be		

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	PROVIDER OR SUPPLIER		580 LE	CADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	between 10:20 a.m. documentation coul Training and Testin updated within the interview during rean EOP from (1) his station. The MS sea	visor (MS) on 01/28/25 and 12:35 p.m., and no d be found to show the g Plan was reviewed and ast year. Based on an cords review, the MS provided s office and (2) the nurse's rehed the Executive Directors de a phone call to the ED but		accomplished for those residents found to have bee affected by the deficient practice? -The alleged deficient practic has the potential to affect all facility occupants. No resider were identified.	ce
	no additional EOP v provided for review 01/03/24, over a yea This finding was ac Maintenance Super	was located. The two EOP's each reflected a review date of ar old.		How other residents have to potential to be affected by to same deficient practice will identified and what correcting actions will be taken? The alleged deficient practical has the potential to affect all facility occupants. No resident were identified.	he be ve tice
				-The administrator reviewed updated the emergency oper plan training and testing plan administrator verified all disar preparedness manuals are current, updated and accessi Manuals are located at the following locations: 1. Administrators Office's 2. Environmental Service's Office The nurse's station. Current will be in-serviced regarding revisions to the emergency play Feb. 23, 2025. The Administrator or their designer review the plan at least annual The Administrator assumes responsibility for and ensures	ations . The ster ster ster ster ster ster ster ste

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/28/2025	
	PROVIDER OR SUPPLIE Y CREEK AT FRA		580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				compliance. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur?	nto
				- Current staff will be in-service regarding the revisions to the emergency plan by Feb. 23, 2. The Administrator or their designee will review the plans least annually. The Administrates assumes responsibility for and ensures compliance. How the corrective actions where the deficient practice will not recur, i.e., what quality assurance program will be printo place?	025. at ator d
				The Disaster and emergency preparedness QAPI tool will be completed monthly for 6 month and then annually. The audit the will be reviewed during the bi-monthly QAPI meeting. Act plans will be completed as needed.	hs ool
E 0041 SS=F Bldg	, ,	8(e), 485.542(e), 485.62 d LTC Emergency Power			
	Based on record re	view and interview, the facility	E 0041	*Deficiency ID: E041	02/14/2025

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	ROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	inspection, testing, found in the Health 110, and Life Safety CFR 483.73(e)(2).	the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could		Completion Date: 2/14/25 Plan of Correction Text: Th facility requests Paper Compliance for this citation	
	Maintenance Super between 10:20 a.m. provided document emergency generated documentation of a MS reviewed his electual not find evided done on the facilities. This finding was ac Maintenance Super	eview and interview with the visor (MS) on 01/28/25 and 12:35 p.m., the facility ation for testing of the or, however, could not provide three year 4 hour test. The ectronic TELS record and ence of a 4 hour run test being as Propane Fired generator. knowledged by the visor at the time of records the exit conference with the		What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? - The alleged deficient practi has the potential to affect all facility occupants. No resident were identified. How other residents have the potential to be affected by the same deficient practice will identified and what corrective actions will be taken? -The alleged deficient practice has the potential to affect all facility occupants. No resident were identified. -3 year four hour load test has been completed on 10/17/202 the on-site spark ignited nature gas generator.	ce ats he he be ve ce ats
				What measures will be put into place or what systemic changes will be made to	

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	OF CORRECTION	IDENTIFICATION NUMBER 155442	A. BUILDING B. WING		COMPLETED 01/28/2025			
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				ensure that the deficient practice does not recur? -Administrator to in-service maintenance director on locat reports from the prior years in TELS by 2/14/25.	-			
				How the corrective actions to be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place?				
				-Maintenance Director to complete the maintenance QA tool monthly x6 months and complete all TELS in tasks tim QAPI tool will be reviewed dui bi-monthly QAPI meeting and actions plans created as need	nely. ring			
K 0000								
Bldg. 01	Licensure Survey w		K 0000	This plan of correction constituthis facility's written allegation compliance for the deficiencie cited. The submission of this pof correction is not an admission or agreement with the deficiencies	of s olan of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
155442		B. WING 01/28/2025					
			<u> </u>	CTD FET. A	DDDEGG OUTV CTATE TIR COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
LUCKODY	CREEK AT FRAN	IIZL INI			MLEY STREET		
HICKOK	CREEK AT FRAN	INLIN		FRAINN	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Provider Number:	155442			conclusions contained in the		
	AIM Number: 1002	290720			Indiana		
					Department of Health's inspec	tion	
	-	Code survey, Hickory Creek at			Report. Hickory Creek at Fran	klin	
	Franklin was found	not in compliance with			respectfully requests		
	Requirements for Pa	-			consideration for desk review	for	
		, 42 CFR Subpart 483.90(a),			this plan of correction in lieu of	f	
	-	re, and the 2012 edition of the			post		
		ction Association (NFPA) 101,			survey revisit.		
	•	LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.					
	•	ity was determined to be of					
		ruction and was fully					
	-	cility has a fire alarm system					
		on in the corridors, spaces					
	-	s and has battery powered					
		all resident sleeping rooms.					
		apacity of 36 and had a census					
	of 27 at the time of	this survey.					
	A 11 1 1						
		idents have customary access					
	-	All areas providing facility					
	-	re sprinklered except for one					
	detached garage wh	ich was not sprinklered.					
	Quality Review con	iduated on 01/30/25					
	Quality Keview con	iducted on 01/30/23					
K 0341	NFPA 101						
SS=F	Fire Alarm System	n - Installation					
Bldg. 01	The Flam Dyolon	i inclanation					
g	Based on observation	on and interview, the facility	K 03	841	Deficiency ID: K341		02/23/2025
		f 1 fire alarm control panels was	11 0.	, 11	Completion Date: 2/23/25		02/25/2025
		2, National Fire Alarm and			• • • • • • • • • • • • • • • • • • • •		
	-	tion 10.10.1 states a means for			Plan of Correction Text: The)	
	turning off activated				facility requests Paper		
	_	e permitted only if it complies			Compliance for this citation.		
		h 10.10.7. Section 10.10.3 states			-		
	_	key-operated or located within					
	a locked cabinet, or	arranged to provide					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/28/2025
	PROVIDER OR SUPPLIER		580 LE	ADDRESS, CITY, STATE, ZIP COD IMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	This deficient pract Findings include: Based on observation of the facility of Supervisor (MS) or and 1:40 p.m., the facility of the facility	on against unauthorized use. ice could affect all occupants. ons and interviews during a with the Maintenance a 01/28/25 between 12:35 p.m. ire alarm control panel (FACP) d. The entire lockset from the		What corrective actions w accomplished for those residents found to have be affected by the deficient practice? - The alleged deficient practice that the potential to affect all facility occupants. No reside were identified.	en tice
	panel door was mis This finding was ac Maintenance Super	sing.		How other residents have potential to be affected by same deficient practice will identified and what correct actions will be taken? -The alleged deficient pract has the potential to affect all facility occupants. No reside were identified. - Key lock was placed on the fire panel located in the nurs station.	the I be ive ice nts
				What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -Maint. Director to complete in-inservice to ensure the fire lock is in place.	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 01/28/2025
	PROVIDER OR SUPPLIEF		580 LE	CADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills			How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? - Maint. Director to complet panel lock audit weekly x4 w and monthly x3 months. Aud to be reviewed during bi-mo QAPI meeting. Action plans created as needed.	e the put e fire //eeks, dit tool nthly to be
	failed to conduct fir quarters. LSC 19.7. conducted quarterly facility personnel (rengineers, and adm signals and emerger	view and interview, the facility re drills on each shift for 1 of 4 1.6 states drills shall be on each shift to familiarize nurses, interns, maintenance inistrative staff) with the ney action required under this deficient practice affects ts.	K 0712	Deficiency ID: K712 Completion Date: 2/23/25 Plan of Correction Text: The facility requests Paper Compliance for this citation What corrective actions was accomplished for those	n. ill be
	Maintenance Super between 10:20 a.m. fire drill occurring of second quarter of 20 addition to the paper searched his electrons	eview and interview with the visor (MS) on 01/28/25 and 12:35 p.m., no record of a during the first shift of the 024 could be located. In rework provided, the MS nic TELS record but was vidence of the drill occurring.		residents found to have be affected by the deficient practice? - The alleged deficient pract has the potential to affect all facility occupants. No reside were identified.	tice

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	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/28/2025	
	PROVIDER OR SUPPLIER Y CREEK AT FRAN		580 LE	ADDRESS, CITY, STATE, ZIP COD EMLEY STREET KLIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION knowledged by the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Maintenance Super	visor at the time of records the exit conference with the		How other residents have the potential to be affected by the same deficient practice will identified and what corrective actions will be taken? -The alleged deficient practice has the potential to affect alleged facility occupants. No resident were identified. -Maint. Director will conduct adocument fire drills on each seat varying times per policy. What measures will be put into place or what systemic	ne be ve e ts	
				changes will be made to ensure that the deficient practice does not recur? -Administrator to conduct in-service with the maintenand director regarding conducting drills at least quarterly on each shift and documenting the drill TELS. How the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be present the deficient program will be present the deficient practice.	fire h l in	

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUIL		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/28/2025		
	PROVIDER OR SUPPLIER			580 LE	ADDRESS, CITY, STATE, ZIP COD MLEY STREET (LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems	s - Essential Electric Syste			into place? -Maintenance Director to complete the maintenance Q tool monthly x6 months and complete all TELS in tasks tir QAPI tool will be reviewed dubi-monthly QAPI meeting and actions plans created as nee	mely. uring d	
Blog. 01	failed to maintain 1 Standby System in Standard for Emerg Systems, Section 8. Health Care Faciliti NFPA 110 Section Emergency Power 9 once within every the assigned class is gree permitted to terminate NFPA 99 Section 6 Type 2 essential election be classified a generator sets. This affect all building of Findings include: Based on records records records records and section 1.	riew and interview, the facility of 1 Emergency Power accordance with NFPA 110, ency and Standby Power 4.9, as required by NFPA 99 es Code, Section 6.4.1.1.6.1. 8.4.9 states that all Level 1 Systems shall be tested at least bree years. Where the eater than 4 hours, it shall be attended to the test after 4 hours. 4.1.1.6.1 states that Type 1 and actrical system power sources at Type 10, Class X, Level 1 as deficient practice could accupants.	K 09	918	Deficiency ID: K918 Completion Date: 2/23/25 Plan of Correction Text: The facility requests Paper Compliance for this citation What corrective actions will accomplished for those residents found to have bee affected by the deficient practice? The alleged defici practice has the potential to a all facility occupants. No residents have the potential be affected by the same deficient practice will be identified and what correcting actions will be taken? The alleged deficient practice has potential to affect all facility occupants. No residents were	i. I be en ent affect dents I to ve	02/14/2025

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between 10:20 a.m. and 12:35 p.m., the facility

provided documentation for testing of the

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identified. -3 year four hour load

test had been completed on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING 01			LETED	
155442		B. W	ING		01/28	/2025	
					_		
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					MLEY STREET		
HICKOR	Y CREEK AT FRAN	NKLIN		FRANK	(LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
1710		or, however, could not provide		1710	10/17/2022 for the on site and	-le	DATE
	" " "				10/17/2023 for the on-site span	K	
		three year 4 hour test. The			ignited natural gas generator.		
		lectronic TELS record and			What measures will be put		
		ence of a 4 hour run test being			into place or what systemic		
	done on the facilities	es Propane Fired generator.			changes will be made to		
					ensure that the deficient		
		cknowledged by the			practice does not		
		rvisor at the time of records			recur?-Administrator to in-serv	/ice	
	review and again at the exit conference with the MS present. 3.1-19(b)				maintenance director on locati	ng	
					reports from the prior years in		
					TELS by 2/14/25. How the		
					corrective actions will be		
					monitored to ensure the		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be pu	ut	
					into place?-Maintenance Dire		
					to complete the maintenance		
					QAPI tool monthly x 6 months	and	
					complete all TELS in tasks tim		
					QAPI tool will be reviewed dur	-	
					bi-monthly QAPI meeting and	iiig	
					,	- d	
					actions plans created as need	ea.	
K 0921	NFPA 101						
SS=F	_	ant Tanting and					
	Electrical Equipm	ent - Testing and					
Bldg. 01	Maintenanc						
		eview, observation, and	K 0	921	*Deficiency ID: K921		06/15/2025
		ity failed to conduct the			Please see Life Safety Code		
	_	nce and maintain complete			Waiver Request related to thi	s	
		nspections for Patient Care			alleged deficiency.		
		Equipment (PCREE). NFPA 99					
		ons 10.3 and 10.5 states the					
	physical integrity, i	resistance, leakage current, and					
	touch current tests	for fixed and portable PCREE					
		uired in 10.3. Testing intervals					
		h policies and protocols. All					
		tient care rooms is tested in					

accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u> COM		COMPL	ETED	
155442		B. W	B. WING 01/28/2025			/2025	
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			MLEY STREET		
HICKOR	Y CREEK AT FRAN	IKI IN			LIN, IN 46131		
HIGROR	I CILLINAT TIVAL	WINCH W		LIVAININ			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ing of several electrical					
		trates compliance with NFPA					
		stem. Service manuals,					
	_	ocedures provided by the					
		de information as required by					
		considered in the development					
		ectrical equipment maintenance.					
		nt instructions and maintenance					
	_	available, and safety labels					
	_	rating instructions on the					
		e. A record of electrical					
		pairs, and modifications is					
		riod of time to demonstrate rdance with the facility's					
	^	esponsible for the testing,					
		se of electrical appliances					
		training. This deficient					
	practice affects all 1	_					
	practice affects and	residents.					
	The findings includ	le:					
	Based on records re	eview and interview with the					
		visor (MS) on 01/28/25					
	between 10:20 a.m.						
		available for review for the					
		EE in use throughout the					
	_	by section 10.5.6.2 of NFPA					
		cilities Code. Observation					
		tour revealed that the facility					
	provided electric be	eds for all residents. The MS					
	_	such as nebulizers, oxygen					
	concentrators, hosp	ital style beds and other					
	_	quipment was present and in					
	use at the facility.	The MS stated that the facility					
	was not aware that	the PCREE was required to be					
	tested.						
	This finding was ac						
	_	visor at the time of records					
	I review and again at	the exit conference with the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155442	B. WI	NG		01/28/2025	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP COD 580 LEMLEY STREET FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID BROVIDER'S BLANCE CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	MS present.						
	3.1-19(b)						

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